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May 5, 2010

MEMORANDUM

TO: Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray
Leza Wainwright

SUBJECT: Implementation Update #72
New VO numbers effective June 1
Records Management
Day Treatment Service Update
NC-IRIS Management
1915 (b)(c) Waiver Update
TCM for Individuals with DD
Processing CAP MR/DD Plans/CNRs by VO
CABHA Verification Update

New ValueOptions Fax Numbers Effective June 1

Effective June 1, 2010 providers must use new fax numbers when faxing requests to ValueOptions. The new fax numbers are toll-free.

	Fax number through 5/31/10	**Fax number effective 6/1/10**
Mental Health/Substance Abuse	919-461-0599	877-339-8753
Developmental Disabilities	919-461-0669	877-339-8754
Residential (Program & Family Type) and Retro Review	919-461-0679	877-339-8757
Health Choice	919-379-9035	877-339-8758

ValueOptions customer service numbers remain unchanged: 888-510-1150 for Medicaid and 800-753-3224 for Health Choice.

Records Management

Safeguarding the Privacy and Security of Records

Implementation Update #58 and Implementation Update #62 reinforced that all providers, including directly enrolled Medicaid providers, are responsible for maintaining custody of the records and documentation to support service provision and reimbursement for the required retention period for publicly funded mental health, developmental disabilities, and substance abuse services. This includes the clinical service record, personnel records and the billing and reimbursement records. The two schedules that specify the length of time that records should be kept are the *Department of Health and Human Services* (*DHHS) Records Retention and Disposition Schedule for Grants*, which is based on the funding source, (found under the third bullet at: http://www.ncdhhs.gov/control/retention/retention.htm) and the *Records Retention and Disposition Schedule for State and Area Facilities*, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) publication, APSM 10-3, which is organized by record type (found on the following website under the subheading, "Other Administrative Publication System Manuals (APS)": http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm#manuals). Providers are subject to the applicable standards outlined in both schedules.

In addition to the Records Retention and Disposition Schedule, the provider's responsibility for safeguarding records is addressed in the *Records Management and Documentation Manual (RM&DM*), the DHHS Provider Administrative Participation Agreement (for direct enrollment) and the Notification of Endorsement Action (NEA) letter. The RM&DM can be accessed at: http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/rmd09/rmdmanual-final.pdf. Sections seven and eight of the provider participation agreement (http://www.nctracks.nc.gov/provider/providerEnrollment/assets/Org.pdf) address the provider's responsibility for the maintenance of records both during and after termination of enrollment. A copy of the NEA is on the Provider Endorsement web page under Administrative Forms: http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm.

Failure to protect consumer privacy and failure to safeguard records and to ensure the confidentiality of individually identifiable health information is a violation of the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy (FERPA) Act, and GS § 108A-80 and GS § 122C-52. The following sanctions, penalties and fees may be imposed for HIPAA violations:

Penalties and Enforcement

- Mandatory investigation and penalties for noncompliance due to willful neglect.
- Willful neglect: $50,000 up to $1.5 million ($10,000 up to $250,000 if corrected within 30 days)
- The Health Information Technology for Economic and Clinical Health (HITECH) Act provides for enforcement by the State Attorney General along with provisions to obtain further damages on behalf of the residents of the state in monetary penalties plus attorney fees and costs.

When a local management entity (LME) is aware of a provider's failure to safeguard the privacy and security of records, such violations should be reported to the LME HIPAA privacy and security officer. If a violation has occurred, the LME may choose to make a report to federal authorities at the Office of Civil Rights http://www/hhs/gov/ocr/privacy/hipaa/complaints/index.html. The DMH/DD/SAS Privacy and Security Officers are to be notified of all such federal filings via e-mail at dmhddsas.hippa.coordinators@lists.ncmail.net.

In the event of a HIPAA breach of consumer information, the provider agency must complete the HIPAA Security Incident Report Form, the HIPPA Security Incident Report Investigation Form, and notify the LME. Based on the outcome of the agency risk assessment, all consumers affected by the breach must be notified of the event and a level I critical incident report must be completed.

Maintaining the Security and Accessibility of Records after a Provider Agency Closes

As stipulated in the DHHS Provider Administrative Participation Agreement and in the provider contract with the LME, a provider's obligation to maintain the records acquired during the course of service delivery extends beyond the expiration or termination of the agreement or contract. This applies to clinical service records and records to support staff qualifications and credentials (personnel records) as well as billing and reimbursement records. The clinical service record should be maintained and accessible to facilitate continuity of care for

individuals who are in need of continued services and supports or who might be in need of services in the future. Providers should also (with consumer authorization as necessary) send copies of transitional documentation (such as Person Centered Plans) to the providers who will be serving the individual. When necessary for coordination of care, copies of documentation could be provided to the consumer directly. The failure to retain adequate and accessible documentation of services provided can result in recoupment of payments made for those services and the termination or suspension of the provider from participating in the Medicaid program. Even after an agency has closed, provider records may be subject to post-payment audits or investigations.

Implementation # 62 provides instructions to be followed in the event that a provider agency ends services or dissolves for any reason. The provider is ***required*** to make arrangements to continue safeguarding both the clinical and reimbursement records in accordance with the record retention guidelines. The abandonment of records or the failure to properly safeguard the security of records is a HIPAA violation which can result in further sanctions and financial penalties as noted above.

Each provider is required to develop a retention and disposition plan outlining how the records are stored, the name of the designated records custodian, how the records custodian is going to inform the respective LME(s) of their process and where the records will be located. The provider should send the responsible LME records chief a copy of the storage logs identifying each individual served within their catchment area, the dates of service and into which box a record is stored. In the event that an agency closes and ceases operation, the provider should notify DMA Provider Enrollment/Computer Sciences Corporation (CSC), the DMH/DD/SAS Accountability Team and the Provider's Endorsing Agency as outlined in Implementation Update # 70.

A LME Medical Records Chief roster is attached for your convenience. If there are additional questions and concerns, please contact Cynthia.Coe@dhhs.nc.gov.

Child and Adolescent Day Treatment Service Update

Implementation Update #71 issued on April 8, 2010 and the updated Clinical Coverage Policy 8A states that day treatment programs cannot operate if a local education agency (LEA), charter, or private school refuses to sign a Memorandum of Agreement (MOA). The DHHS has addressed this issue with the Centers for Medicare and Medicaid Services (CMS) and the following is further clarification.

The MOA between the day treatment provider and the LEA, private or charter school is highly encouraged, but is not a requirement for endorsement as a day treatment provider. It should be noted that the purpose of an MOA is to ensure that all relevant parties (LEA, LME, provider) understand and support the primary purpose of the day treatment service definition which is to serve children who, as a result of their mental health and/or substance abuse treatment needs, are unable to benefit from participation in academic or vocational services at a developmentally appropriate level in a traditional school or work setting. The provider is to implement therapeutic interventions that are coordinated with the child's academic or vocational services available through enrollment in an educational setting. These interventions are designed to reduce symptoms, improve behavioral functioning, increase the individual's ability to cope with and relate to others, promote recovery, and enhance the child's capacity to function in an educational setting, or to be maintained in community based services.

Implementation Update #70 issued on March 2, 2010 contains an attachment titled "**Elements to Consider Including in the Memorandum of Agreement (MOA) for the Implementation of Child and Adolescent Day Treatment Services."** This is to clarify that the elements noted in the MOA are *suggested*; that is, they may be considered, but are not mandated to be included in any MOA between the LEA, charter, or private school, the provider and the LME. Day treatment providers, LEAs, private, or charter schools, and LMEs may use these suggested elements as they consider MOAs or working agreements going forward.

NOTE: Day treatment services are designed for children who require treatment to address functional problems associated with participation in school. Day treatment programs may **not** operate as simply after-school programs.

NC Incident Response Improvement System (NC-IRIS) Implementation

The new web based incident reporting system, NC-IRIS, will be implemented on May 1, 2010. NC-IRIS will be ready to receive and process incident reports on this date. The web site address for connecting to NC-IRIS is: https://iris.dhhs.state.nc.us/

Providers who have been trained to use NC-IRIS are required to begin submitting incident reports through NC-IRIS on May 1, 2010. Providers who have not been trained to use NC-IRIS are requested to contact their LME for training so that they can begin using the new incident reporting system as soon as possible.

Effective July 1, 2010, all mental health, developmental disability, and substance abuse service providers who are required to participate in the DHHS incident reporting system shall be required to use NC-IRIS. Providers should contact their LME if they have questions about this new system.

Due to the many functions built into NC-IRIS, the system is very sophisticated; errors may occur during the start-up phase. All providers are asked to report to their LME any errors that occur and any problems they encounter.

Providers who do not begin submitting incident reports through NC-IRIS on May 1, 2010 are to continue submitting paper copies of Level II reports to their LME and continue submitting Level III reports to their LME and the DMH/DD/SAS Quality Management office (fax number 919-508-0986). Providers are to also continue to submit the paper incident reports to other entities as needed (DHSR Healthcare Personnel Registry and the DHSR Complaint Intake Unit, etc.) These providers are to use the newly revised reporting form, Form QM02, effective October, 2004, revised April 27, 2010. This form may be found http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm under **"Incidents."**

NOTE: Effective July 1, 2010, the use of *DHHS Incident and Death Report*, form QM02 will be discontinued.

1915 (b)(c) Waiver Update

Four LMEs responded to the request for applications (RFA) to participate in the State's 1915 (b)/(c) Medicaid Waiver. The four LMEs are: East Carolina Behavioral Health, Mecklenburg County Area MH/DD/SAS, Sandhills Center for MH/DD/SAS, and Western Highlands Network. DHHS will not make additional comment on the review process until the formal announcement is made in July 2010.

Targeted Case Management Services (TCM) for Individuals with Developmental Disabilities

This serves to provide clarification regarding information provided in the April 8, 2010 Implementation Update #71 regarding case manager qualifications in the Medicaid State Plan Amendment for *Targeted Case Management (TCM) Services for Individuals with Developmental Disabilities.* Based on staffing qualifications and equivalencies in 10A NCAC 27G.0101, a graduate of a college or university with a bachelor's degree in a field other than human services who has four years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served is equivalent to a bachelor's degree in a human services field with two years of accumulated MH/DD/SAS experience working with the population served.

The endorsement check sheet and instructions for *Targeted Case Management (TCM) Services for Individuals with Developmental Disabilities* will be posted on the DMH/DD/SAS website: http://www.dhhs.state.nc.us/MHDDSAS/

Processing Initial CAP-MR/DD Plans and Continued Need Reviews by ValueOptions

In order to expedite the processing and approval of Initial CAP-MR/DD Plans and Continued Need Reviews (CNR) providers should be sure to submit all the elements listed in Implementation Update #59. In order to remind you of the requirements following are the required documents for DD submissions to ValueOptions for review to occur:

Continued Need Review (CNR): CAP

- Person Centered Plan (PCP) with signatures and cost summary
- MR2
- CTCMs – all services requested
- NC SNAP (four pages and Summary Report/Supplemental Information sheet)
- For equipment/supplies – justification/assessment, physician order or prescription, price quote (two quotes required for Home Modifications/Augmentative Communication /Vehicle Adaptation)
- Proof of insurance for Vehicle Adaptation
- Completed Risk Identification Tool
- Non CAP Medicaid supplies billed through the LME require prescriptions

PCP (Initial CAP)

- PCP with signatures and cost summary
- MR2 with prior approval date and number
- CTCMs - all services requested
- NC SNAP (four pages and Summary Report/Supplemental Information sheet)
- Current psychological
- For equipment/supplies – justification/assessment, physician order or prescription, price quote (two quotes required for Home Modifications/Augmentative Communication/Vehicle Adaptation)
- Proof of insurance for Vehicle Adaptation
- Completed Risk Identification Tool
- Non CAP Medicaid supplies billed through LME require prescriptions

Revision (CAP)

- PCP update with signatures and cost summary
- CTCMs
- For equipment/supplies – justification/assessment, physician order or prescription, price quote (two quotes required for Home Modifications/Augmentative Communication/Vehicle Adaptation)
- Proof of insurance for Vehicle Adaptation

CAP Provider Change Only

- Cost summary
- CTCM to discharge previous provider
- CTCM to add new provider

Person Centered Plan Instructions: CAP-MR/DD ONLY!!!

In the *PCP Instruction Manual* there is an item that needs revision and clarification. On page 35, *section III*: *Legally Responsible Person* includes the CAP choice statement. All individuals who receive CAP funding or their legally responsible person (LRP) must sign to confirm their understanding of their choice to participate in the CAP-MR/DD waiver. Therefore, this section III must be signed by either the guardian/LRP or **the individual, in the event they are their own guardian** and check all three of the boxes since the CAP choice statement is not included in Section II on the signature page.

Critical Access Behavioral Health Agency (CABHA) Verification Update

The verification stage of the Critical Access Behavioral Health Agency (CABHA) certification process originally required the provider to demonstrate 60 days of history of implementation of the policy (provision of core services and required positions carrying out defined job responsibilities). This requirement has now been reduced to **30 days** of history. Agencies that have received notification of meeting the desk review elements should notify the LME System Performance Team at www.contact.dmh.lme@dhhs.nc.gov when they have the **30 days** of history.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

cc: Secretary Lanier M. Cansler
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